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Name of counselor _____

Dates seen A A _____

Explain what happened A A _____

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MEDICAL INFORMATION: Have you seen a doctor within the past year? YES NO
If yes, what was the reason? _____

Who is your doctor? _____ Phone _____

Are you taking any kind of medicine (prescription or over-the-counter)? YES NO

Please list any medicines that you are taking: _____

Do you have allergies to anything? YES NO
Please describe any allergy problems you may have: _____

SUBSTANCE USE HISTORY

Do you use/have you used tobacco (any form)?	Current	Past	No
Do you use/have you used alcohol?	Current	Past	No
Do you use/have you used caffeine (any form, including cola drinks)?	Current	Past	No
Do you use/have you used recreational drugs?	Current	Past	No